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VIA EMAIL AND FEDEX

July 23, 2009

Mr. Paul E. Parker
Chief, Certificate of Need
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Re: Completeness Review Responses
Clarksburg Community Hospital
Matter No. 09-15-2294

Dear Mr. Parker:

Enclosed with this letter are 10 copies of our responses to the questions prepared by Commission staff (letter Parker to Hall, June 18, 2009).

I certify that a copy of this response has also been forwarded to the appropriate local health planning agency, as well as other applicants and those persons designated by the Health Facilities Coordination Office, as noted below.

We continue to look forward to working with you and the staff of the Commission during the course of the review of this application.

Should you have any additional questions, please contact Christopher C. Hall, at 301-315-3037.

Very truly yours,

RT Coughlan

Richard J. Coughlan

Enclosures

CR+K

cc: Ulder J. Tillman, M.D., MPH, Montgomery County Health Department
Ken DeStefano, Esq.
Howard Sollins, Esq.
Jack Tranter, Esq.

1. Regarding the response to Completeness Question 7, please provide a complete breakdown of the $6,500,000 included in the budget (Attachment 4) for site preparation and land improvements.

Applicant Response:

The $6,500,000 listed in the budget for site preparation and land improvements is allocated in the following manner:

Site Preparation and Land Improvements		
Demolition		$ 35,000
Site Rough Grade		50,000
Site Prep (non building)*		
Excavation	2,250,000	
Utilities	1,600,000	
Concrete/paving	1,275,000	
Other	81,750	
Site Prep (non building) Subtotal	5,206,750	5,206,750
Storm Drainage		471,000
Building Excavation-excav, backfill, fdn drain, subgr		407,250
Landscape		270,000
Other		60,000
	TOTAL	$6,500,000

*Non-Building Site Prep includes - topsoil strip/stockpile, site excavation (cut/fill/compaction), soil haul in/off, site utilities (water, gas, electrical, sanitary sewer, etc.), site subgrade preparation (compaction, grading, gravel treatments), site concrete (sidewalks, curb/gutter, paving, retaining walls, utility pads, dock walls, pole bases, etc.), site asphalt paving and striping, light poles, handicap signage, fencing and soil treatments.

2. Regarding the response to Completeness Question 8, staff has not been able to duplicate the calculation of the future inflation of $6,957,000 based on information provided. Please submit the complete calculation of the $6,957,000 inflation allowance.

Applicant Response:

The details of the inflation allowance calculation are provided on Attachment 1. Please note that the inflation allowance calculation includes: 1) deflation of the HBE budgeted construction amount (plus contingency) which was stated in October 2010 dollars from October 2010 to April 2009 - 18 months; 2) inflation of the HBE budgeted construction amount (plus contingency) from October 2010 to the start of construction in April 2011 - 6 months; and 3) inflation of all other capital cost components from April 2009 to the start of construction in April 2011 – 24 months. The assumed inflation rate is 2.5%.

3. Completeness Question 11 requested that the project budget be submitted in the form specific in the application including lease costs at the bottom of the form. The revised project Budget submitted in response changed other equipment to minor equipment as specified in the application form, but does not include the lease costs. It also reports capitalized construction interest (net) instead of gross interest as requested on the form. Please submit a revised project budget in the form specified (see attached form) with estimated gross construction period income reported as a use of funds and estimated interest income reported as a source of funds. Also report the lease cost for the land on the bottom of the form as specified.

Applicant Response:

Please see Attachment 2 for the revised Project Budget that includes: 1) the gross components of construction period interest expense and interest income, and 2) the lease cost disclosure in the prescribed format at the bottom of the Project Budget. Details of the construction period interest expense and interest income calculations are provided in the response to Question 5, below.

4. Completeness Question 13 requested "A more complete specification of the capital cost items included under Line A.1.c.(4), eliminating the "Other" specification of $1,688,999 by specifically stating what is being purchased for this expenditure. Briefly explain why the specified items are most appropriately included as "other" capital costs rather than included on other line items of the budget, such as Lines A/1/a(1) through (6)." The response only appears to address the $1,688,000 formerly included on line A.1.c(4)e. Please explain why budgeted costs on lines A.1.c.(4)a through c are included as "other" capital costs rather than included on other line items of the budget, such as Lines A.1.a.(1) though (6). Submit a more detailed explanation of what is included on each of these lines especially the type of consulting services and explain why these costs should not be included on one of the New Construction lines A.1.a.(1) through (6).

Applicant Response:

"Other" capital costs (identified on Lines A1.c.(4) a. through c.) are separately identified in the Project Budget because 1) these costs have shorter useful lives than the building, fixed equipment, site preparation and architect/engineering costs identified in on Lines A1.a(1) through(6) and 2) the budget for these costs were developed from sources different than other capital costs identified on the Project Budget. MIS/Signage/Security (Line A1.c.(4)a.) is the budget for interior and exterior signage ($656,000) and security systems ($768,000). IT/Telephone fit-out (Line A1.c.(4)b.) is the budget for IT equipment ($5,207,000) and telecommunications systems ($980,000). Consulting services (Line A1.c.(4)c.) is the budget for services related primarily to equipment acquisitions ($750,000). Please see the revised Project Budget in Attachment 2 for all details.

5. Regarding the response to Completeness Question 14, please submit the detailed calculation of the gross construction period interest and the interest income. What is the assumed interest rate on the bond proceeds that will be invested during construction? What are the assumptions regarding the draw downs of such funds and the balances that will remain invested.

Applicant Response:

Please see Attachment 3 for a detailed calculation of gross construction period interest and interest income. As disclosed in the assumptions at the bottom of Table 3 (originally submitted), the assumed interest rates on the trustee held funds are approximately 3.0% for the debt service reserve fund and 2.0% for the construction fund and the capitalized interest fund. Project payments from the construction fund are assumed to be drawn down evenly over the construction period, and interest payments are assumed to be drawn out of the capitalized interest fund every 6 months, by June 30 and December 31 of each year during the construction period.

6. In responding to Completeness Question 20, the applicant indicated that it is justifying the MSGA bed capacity proposed for this project under Part (c) (iii) of Project Review Standard (2), Identification of Bed Need and Addition of Beds. Part (c) (iii) requires the applicant to demonstrate that the need for bed capacity exceeds the minimum jurisdictional bed need projection, which, in the case of Montgomery County, is 1,007 MSGA beds. Clarksburg Community Hospital (CCH) has projected a 2017 MSGA bed need for a hypothetical primary service area comprised of 13 zip code areas, using a methodology that is similar, methodologically, to the methodology used by MHCC to create MSGA bed need forecasts. The result is a projected need in the service area for 146 MSGA beds in 2017, 43 beds more than the 103 beds identified as needed in 2007 to serve actual demand in that year at an average annual occupancy rate of 75%. Please respond to the following question regarding this response to Completeness Question 20:

a. The arithmetic in Attachment 5 is incorrect. Projected 2017 average length of stay ("ALOS") for persons aged 15-64 (3.42 days) assume that average length of stay will decline at an average of 1.0% per year for this age group between 2007 and 2017. The two variable rates of change identified for use in ALOS projection are a decline of 0.1% per year (5-year trend) or 0.2% per year (10 year trend). Please correct and resubmit this table;
b. Explain how this service area projection demonstrates the need for more than 1,007 MSGA beds in Montgomery County by 2016;
c. Given that CCH's response to this question is a service area analysis with accompanying bed need projections for the service area, why is CCH demonstrating a need for this project under Part (c)(iii) of Project Review Standard (2) rather than Part (c)(iv)?
d. Explain how this projection demonstrates the need for construction of 82 MSGA beds in this area. Attachment 5's table indicates that this area generated demand for 103 beds in 2007, a demand that was met by existing hospital beds. CCH projects that in 2017, the area will generate demand for an additional 43 MSGA beds (or, correcting for the arithmetic error noted in 6.a above and using the correct occupancy rate scale of the State Health Plan, an additional 29 to 41 beds). Why can't this projected additional increment of demand also be met by existing hospitals?
e. Explain the choices made in the service area bed need projection. Specifically:

    i. Why is the service area use rate for the 15-64 age group more likely to grow at the faster pace of the last ten years rather than the slower pace of the more recent 5-year period?
    ii. Why is the service area use rate for the 65+ age group more likely to decline at the slower pace of the last ten years rather than the faster pace of the more recent 5-year period?
    iii. Why is the ALOS of the 15-64 age group more likely to decline at the slower pace of the last 5 years rather than the faster pace of the last ten years, when the ten year trend was relied on for predicting the change in use rates? (We are assuming that CCH was attempting to forecast on the basis of a decline of 0.1% per year in

the 15-64 ALOS when the arithmetic error occurred. However, your response to Part a of this question may prove otherwise.)

Provide the basis for these choices. Please provide the evidence on which CCH relied that demonstrates that the maximum target values (i.e., the target values that produce the maximum number of beds projected (as needed in the future), are the correct choices for this service area, across the board.

f. Explain why an occupancy rate of 75% was used to project the bed need for 2017 when the projected average daily census of 109 would call for an average annually occupancy rate target of 80%, consistent with COMAR 10.24.10.05D(4).

Applicant Response:

The following is offered in response to the Question found under a. above:

Two corrected tables are shown in Attachment 4. These tables correct for the arithmetic error, and also provides the high and low range of PSA bed need associated with both the low and high target values for ALOS and discharges rates based on CY 2008 discharges. Our view is that the correct choices for MSGA services are probably between the high and low range of bed need for the CCH PSA.

The following is offered in response to the Question found under b. above:

The need for the CCH can be demonstrated under Part (c) (iii) of Project Review Standard (2). Identification of the Bed Need and Addition of Beds.

Under Part (c) (iii), as shown below, the need for CCH's 82 MSGA beds is greater than the Montgomery County minimum net jurisdictional bed need projection of –61 as updated for CY 2008 MSGA patient day data. By 2016, we forecast that there will be a minimum net need for 95 additional MSGA beds in Montgomery County.

The minimum jurisdictional bed need projection for Montgomery County is for 1,007 MSGA beds by 2016. This bed need projection assumes that there will be approximately 294,000 MSGA patient days provided in Montgomery County hospitals by 2016. We have interpolated the need for MSGA beds for each period between 2008 and 2016.

In CY 2008, there were actually 287,363 MSGA patient days reported by Montgomery County hospitals, indicating a need for 984 beds, 44 more than the State Health Plan minimum jurisdictional bed need projection for Montgomery County, and 77 fewer than the maximum jurisdictional bed need projection for 2008.

Year	Actual MSGA Patient Days	Minimum SHP Forecast	Maximum SHP Forecast	Actual Bed Need	Minimum Bed Need	Maximum Bed Need
2004	260,500	264,670	276,416	892	906	947
2005	251,000	267,120	284,739	860	915	975
2006	262,129	269,570	293,062	898	923	1,004

2007	276,000	272,020	301,385	945	932	1,032
2008	287,363	274,470	309,708	984	940	1,061

Source: CR+K.

You will note from the actual patient day data reported above shows a significant increase in MSGA utilization after CY 2004. If these trends in increasing annual MSGA utilization continue in Montgomery County hospitals, by 2016, we forecast that 326,124 MSGA patient days will be provided indicating a need for 1,185 MSGA beds at 80% occupancy, 176 more than the current State Health Plan minimum jurisdictional bed need projection, and 104 fewer than the maximum.

Year	Forecasted MSGA Patient Days	Minimum SHP Forecast	Maximum SHP Forecast	Forecasted Bed Need	Minimum Bed Need	Maximum Bed Need
2009	291,016	276,920	318,031	997	948	1,089
2010	298,889	279,370	326,354	1,024	957	1,118
2011	306,761	281,820	334,677	1,051	965	1,146
2012	314,634	284,270	343,000	1,078	974	1,175
2013	322,507	286,720	351,323	1,104	982	1,203
2014	330,379	289,170	359,646	1,131	990	1,232
2015	338,252	291,620	367,969	1,158	999	1,260
2016	346,124	294,073	376,297	1,185	1,007	1,289

Source: CR+K.

This suggests that the physical bed capacity of Montgomery County hospitals will need to expand before 2016 in order to address this forecasted need for MSGA patient days. Otherwise, the needed bed capacity to sustain the forecasted growth in patient days will be insufficient if there are only 1,090 MSGA beds physically available in Montgomery County hospitals. The proposed CCH is the best alternative project for expanding MSGA physical bed capacity prior to 2016.

As of July 1, 2009, there are 1,090 licensed MSGA beds, and no CON-approved beds located in Montgomery County hospitals, indicating that Montgomery County's 2016 net bed need ranges between –83 beds and 199 beds. According to our forecasts, by 2016, the net bed need will thus range between a minimum of 95 and a maximum of 199 additional MSGA beds. Among the needed additional MSGA beds for Montgomery County are the 150 to 174 total beds needed to serve the future residents of the CCH PSA, a portion of which are already licensed to other hospitals. The 82 MSGA beds proposed for CCH from within this bed number will address both some of the forecasted needs of future PSA residents, as well as the needs of non-PSA residents.

For this reason, the approval of the CCH is consistent with the State Health Plan standard found at COMAR 10.24.10.04 B. (2) (c) (iii), because the additional 82 MSGA beds proposed for CCH exceed the 1,007 minimum jurisdictional bed need projection and do not exceed the 1,289 maximum jurisdictional bed need projection, and are well within the

minimum jurisdictional net bed need projection of 1,185 MSGA beds as updated for actual CY 2008 actual MSGA utilization, as demonstrated above. We believe that the need for the 82 proposed MSGA being proposed at the CCH has been demonstrated to be needed in excess of the minimum jurisdictional bed need projection of 1,007 MSGA beds.

The following is offered in response to the Question found under c. above:

We determined that Part (c)(iii) of Project Review Standard (2) is more appropriate than Part (c)(iv) for the following reasons. Based on the current and historical language, (iv) applies when an applicant hospital is seeking beds "in addition to" the calculated bed need projection, i.e. outside the "min/max" bed need projection. However, (iii) applies when the applicant is seeking beds above the minimum but below the maximum. That's why (iv) does not mention the "min/max" projection but (iii) does mention it.

Each of (iii) and (iv) have a different source. The language under (iii) was added in a June, 2008 report of the MHCC, following the submission of informal comments on the then-Proposed Chapter. Hal Cohen, representing CareFirst, pointed out an erroneous citation in what was then (iii) but is now (iv). In looking into to that comment, the MHCC staff agreed there was a mis-citation to Regulation .05C(3), which instead should have referred to CON Program Policy 3.A in Section .05C of the prior Chapter that was being updated. If one refers to page 24 of the prior version of the Chapter, one can see the parallel language in former .06A(a)(1) that was used as the basis for what is now .04B(2) in the current chapter, but updated to reference the "maximum" bed need number. Also, on page 16 of the prior version of the Chapter, there is CON Program Policy 3A to which the Staff referred in the June, 2008 report and that supported the insertion of the new language under (iii), as it now appears. Also, it is evident that current "(iv) is based on former CON Program Policy 3B.

Thus, the "service area" analysis under (iv) is different from the manner in which an applicant proposing to meet a need within the minimum/maximum range is demonstrated. CCH's application explains how it will meet the needs of the population in the relevant zip codes.

The primary service area analysis provided in the CON application and in the response to the first set of completeness questions was intended to address the requirements of COMAR 10.24.10.04 B. (2) (c) (iii) as the burden is on the applicant to demonstrate need at the applicant hospital for bed capacity that exceeds the minimum jurisdictional bed need projection. While there is no requirement in Part (c) (iii) of Project Review Standard (2) that an applicant demonstrate need using the projection methodology, assumptions and targets contained in Regulation .05 of COMAR 10.24.10 as set forth in Part (c) (iv) of Project Review Standard (2), we have updated the current State Health Plan bed need projection based on the actual CY 2008 MSGA utilization. When the actual utilization data for the Montgomery County hospitals are trended forward through 2016, the minimum net bed need of –61 changes to a positive net bed need of 95, thus permitting the approved of the 82 additional MSGA beds in Montgomery County above the 1,090 MSGA beds currently licensed.

When the projection methodology, assumptions and targets contained in Regulation .05 is updated for the actual MSGA patient days reported by Montgomery County hospitals in CY 2008 and trended forward, the minimum net bed need of –61 becomes a positive net bed need of 95, indicating a need for additional MSGA beds above and beyond those 1,090 MSGA beds currently licensed. CCH is intended to address a portion of this forecasted MSGA bed need.

The following is offered in response to the Question found under d. above:

While CCH has demonstrated that the 82 MSGA beds it has proposed are needed and consistent with Project Review Standard (2). Identification of the Bed Need and Addition of Beds, if the Commission determines that the 24,042 forecasted patient days for MSGA services at CCH in 2015 can be better accommodated by existing hospitals, it will accept this finding, and expand the physical MSGA bed capacity of Shady Grove Adventist Hospital as the preferred alternative. Currently, Shady Grove Adventist Hospital is licensed for 239 MSGA beds, and with some renovations, can provide additional patient rooms to permit up to 239 MSGA beds to be furnished, staffed and occupied by future MSGA patients.

The following is offered in response to the Question found under e. above:

We have updated the forecasts of future MSGA patient days to include CY 2008 utilization data. In our view, the pace with which the discharge rates and average length of stay changes for the two age cohorts between 2008 and 2017 cannot be accurately predicted simply on the basis of past trends. For that reason, we have provided both a high range and low range forecast. In our view, the growth in future MSGA utilization is likely to be between the high and low forecast.

The following is offered in response to the Question found under f. above:

The occupancy rate of 75% was used to project the PSA bed need for 2017 because the requirement found at COMAR 10.24.10.05 D(4) states that the jurisdictional minimum occupancy standards used in calculating gross bed need are based on the average daily census projected for the jurisdiction, applied at the hospital level. Because the 82 MSGA beds proposed for CCH will have an average daily census of less than 99 days, the 75% minimum occupancy rate applies.

7. The response to Completeness Question 21 does not detail the projected cost (both capital and operating) of expanding Shady Grove Adventist Hospital and, possibly, Frederick Memorial Hospital, to meet any increase in the need for hospital services in the communities between Gaithersburg and Frederick. Please address this requirement of Project Review Standard (5), Cost Effectiveness. Please assure that this standard is addressed in full as it is written.

Applicant Response:

As we explained in our response to Completeness Question 21, the establishment of the CCH, by definition, is a more cost-effective alternative than expanding either Shady Grove Adventist Hospital or Frederick Memorial Hospital for improving the geographic access to hospital services among residents of the communities between Gaithersburg and Frederick.

The principal goal and limited objective of this project is not only to meet the increase in need for hospital services, but to provide an alternative facility to: 1) the existing hospitals that currently serve these communities, and 2) the new hospital proposed by Holy Cross for Germantown (Docket No. 08-15-2284). For this reason, we believe that we have addressed the requirement set forth at Subsection (b) of Project Review Standard (5), Cost Effectiveness because there is only one practical approach to expanding geographic access for the residents of the rapidly growing upper Montgomery County and lower Frederick County communities and that is to establish the CCH.

Nothing in this standard requires that an applicant for a new hospital consider alternatives that are not being proposed for Commission approval, such as the expansion of Shady Grove Adventist Hospital or Frederick Memorial Hospital.

Shady Grove Adventist Hospital is planning a renovation project for which a determination of exemption will be submitted that would permit the expansion of physical bed capacity to accommodate some or all its 239 licensed MSGA beds within the coming 12 months. This project can be undertaken for less than $10 Million, and therefore would not be subject to CON review.

Other hypothetical alternatives, which would involve significant capital expenditures for expansion of physical bed capacity at either Frederick Memorial Hospital or at Shady Grove Adventist Hospital exceeding their current licensed bed capacity, have not yet been analyzed in any meaningful way. There are no estimates regarding the scope of such expansions, their capital costs, their financial feasibility, or their impact on operating expenses. It is a purely hypothetical alternative that does not address the demonstrated need for CCH, and its unique ability to improve geographic access. No alternative to CCH is "CON-ready." Adventist HealthCare and Frederick Memorial Hospital have been planning for the development of the Clarksburg campus to meet recognized needs.

The leadership of Shady Grove Adventist Hospital and Frederick Memorial Hospital support the establishment of CCH as the best way to improve geographic access to inpatient care for the fast growing communities of upper Montgomery County and lower Frederick County. At

the appropriate time in the comparative review, CCH will provide a thorough analysis of why CCH is a more cost-effective alternative than the Holy Cross Hospital proposed for Germantown.

In the event that the Commission denies this CON application for CCH, Shady Grove Adventist Hospital will certainly study a suitable major expansion project at Shady Grove Adventist Hospital to meet identified Montgomery County needs for the future consideration by the Commission.

8. Completeness Question 22 requested the submission of a detailed description of the methodology and assumptions used to project 1,303 inpatient surgical cases and 3,183 outpatient surgical cases at the proposed hospital in 2015. The response did not include a description of such a methodology. Please provide a detailed description of the factors that went into the projection of the inpatient and outpatient surgical cases and how those factors contributed to the volume projections. Submit all calculations and explain the basis for all assumptions.

Applicant Response:

In order to forecast the 1,303 inpatient surgical cases and the 3,183 outpatient surgical cases at the CCH in 2015, we assumed that between twenty-three and twenty five surgeons would provide an average of 150 outpatient and outpatient surgeries per year.

The number of surgeons practicing at Shady Grove Adventist Hospital and at Frederick Memorial Hospital is certain to grow between now and 2015, as a result of their attractive locations and growing service area populations.

Given the availability of a new 100-bed hospital, the utilization of its four operating rooms will be dependent upon the preference of community-based, private practice surgeons and their patients to utilize a brand new hospital located in a high-growth area with a state-of-the-art surgery department with all the necessary staff and equipment to provide elective inpatient and outpatient surgery of limited scope and duration, complementary to the two existing hospitals that currently serve most of the residents of the area. We are not interested in duplicating the operating room capacity of either Shady Grove Adventist Hospital or Frederick Memorial Hospital, but we do believe that surgeons who practice at these two hospitals will "follow their patients" to CCH.

9. Regarding the response to Completeness Question 23, please provide the following clarifications:

a. Please explain the reasons for excluding each of the items that have been excluded from the new construction building cost for comparison with a Marshall Valuation Service Guideline cost (the difference between $80,294,000 and $70,653,000); and

b. The response does not include a detailed breakdown of what is included in the $5,206,750 extraordinary adjustment for site preparation costs as requested. Please provide such a breakdown. Does it include the cost of installing utility lines from the property line to the hospital? If yes, specify such costs. Does it include off-site costs? Does this amount include the cost of building excavation, backfill and finish grading? If any of these costs are included in the extraordinary adjustment, please estimate the cost of each cost item. If any of these costs are not included in the extraordinary adjustment, specify where such costs are included in the project budget?

Applicant Response:

The following is offered in response to the Question found under a. above:

The original completeness review responses submitted on May 29, 2009 included a revised MVS schedule which was labeled as Attachment 6, and the footnote included on the second page of Attachment 6 detailed 11 items amounting to $9,641,000 that provide the reconciliation from the $70,653,000 Building – New Construction component included in the MVS schedule and the $80,294,000 Building – New Construction component presented on the Project Sources and Uses Schedule. These items were excluded from the MVS schedule as we understand that MVS does not include these items in the comparable cost calculations. Furthermore, the $4,450,000 Construction Upgrades - estimate represents a builder's contingency allowance which will likely not be spent on items that are known to be included in the MVS calculations.

The following is offered in response to the Question found under b. above:

Site Excavation - $2,250,000 (strip/stockpile topsoil, cut/fill/compaction, haul off/in)
Site Utilities - $1,600,000 (water, gas, electrical, sanitary sewer, etc. from property line to building including connections to both)
Site Concrete and Site Paving - $1,275,000 (grading, gravel, sidewalks, curb, site walls, concrete paving, pole bases, asphalt paving)
Other Site Work - $81,750 (pole bases, handicap signage, fencing, soil treatments, striping, etc)
Total Site Prep (non Building) - $5,206,750

10. Regarding the response to subsection (c) of Completeness Question 27, please explain the basis for the market share assumption for each zip code area, as presented in Attachment 10 of the CON application.

Applicant Response:

In FY 2008, there were 41,524 outpatient ED visits to Maryland hospitals and to the Germantown Emergency Center. We assumed that had CCH been operating in FY 2008, approximately 52% of those visits would have been to CCH due to its proximity to the thirteen zip code areas in its proposed PSA. By 2015, if the growth in ED visits among PSA residents were approximately 3.5% per year, the number of outpatient visits to CCH would grow to 27,306 visits. To be conservative, we forecasted 24,560 outpatient visits to CCH in 2015 from all areas.

To estimate the market share by zip code area, we divided the PSA into six categories, and assigned a market share percentage to each based upon our local knowledge of these communities, their proximity to I-270 and local roadways to the CCH site, and anticipated care-seeking preferences by their residents:

Home (Clarksburg), 90%;
Northern Tier (Monrovia, Ijamsville, Adamstown), 75%;
Rural (Barnesville, Beallsville, Boyds, Dickerson, Urbana, Damascus), 70%;
Germantown, 20876, 60%;
Germantown, 20874, 35%; and
Gaithersburg, 20882, 30%.

11. Regarding the response to Completeness Question 28, please provide the following clarifications:

a. It is not clear how the Primary Service Area fertility rates were factored into the projected utilization. Please explain and submit calculations; and
b. On page 21 of the completeness response it states that "the annual increase in Obstetric discharges would be 1% per year in order to be conservative recognizing the projected demographics of the PSA." On page 57 of the application it states that "for obstetrics discharges, we assumed a .5% growth per year." Please reconcile these two statements

Applicant Response:

In our response to Completeness Question 28, we did not rely upon a mathematical model to project the volume of obstetrical discharges at the proposed CCH in 2015, in which PSA fertility rates were factored into the projected utilization calculations. In fact, such fertility rates cannot be reasonably calculated for the CCH PSA because they are reported on a County-wide basis. Our citation to the Maryland Vital Statistics for Montgomery County was to illustrate the historical growth in demand for Obstetrics services generally since 2004.

We believe that the number of births among County residents and at Montgomery County hospitals will continue to grow in the future, and that CCH will very likely share in this growth.

With respect to the discrepancy between the 1% annual growth in obstetrics discharges found on p. 57 of the application, and incorporated into the projections of obstetrical discharges, and the .5% growth cited in the Response to Completeness Question #28, the .5% growth was an error.

12. Regarding the response to Standard .04(4) Medicaid Access, subsection (b) and Completeness Questions 29, specify the number of physicians with admitting privileges at Shady Grove Adventist Hospital ("SGAH") who provide obstetric or pediatric services for women and infants and who participated in the Maryland State Medical Assistance program.

Applicant Response:

In 2008, 81 physicians performed 667 deliveries for Medical Assistance enrollees. All of these physicians will be invited to remain on the medical staff at the new facility location.

13. Regarding the response to Completeness Question 31, please provide the following clarifications:

a. On page 24 it states that there are 31,814 HealthChoice recipients in Montgomery County enrolled as of March 31, 2008. It also states that 31,814 lived in the Montgomery – North local access area, which includes the proposed Primary Service Area of CCH. Since it is unlikely that the number of HealthChoice recipients for all of Montgomery County and a portion of Montgomery County as the same, please revise as necessary;
b. Identify the zip code areas included in the Montgomery – North local access area;
c. Identify and quantify any current unmet needs for obstetric and perinatal care in SGAH's service area and Frederick Memorial Hospital's service area (the population that is not currently served or has specific problems accessing services) that will be satisfied by the proposed new hospital and obstetric service in Clarksburg;
d. Submit measurable and time-limited goals and objectives for health status improvements to which the Community Benefit Plan for Obstetric and Perinatal Services can be evaluated;
e. Submit information on the structure, staffing and funding of the Plan; and
f. Document community support and describe community involvement in program planning for the Community Benefit Plan for Obstetric and Perinatal Services.

Applicant Response:

The following is offered in response to the Question found under a. above:

The total number of HealthChoice recipients residing in Montgomery County as of March 31, 2008 was incorrectly cited in our response to Completeness Question 31. There were actually 65,572 enrollees. 31,814 were residing in the Montgomery County – North Local Access Area.

The following is offered in response to the Question found under b. above:

The zip code areas included in the Montgomery County – North Local Access Area is found at COMAR 10.09.66.06.E., and are found in Attachment 5

The following is offered in response to the Question found under c. above:

To the best of our knowledge, there are currently no unmet needs for obstetric and perinatal care in SGAH's service area and Frederick Memorial Hospital's service area. Both of these hospitals operate large and growing perinatal programs capable of addressing nearly every type of obstetrical and neonatal case.

The proposed Obstetrics service at CCH is meant to expand geographic access to future residents of the communities located between Gaithersburg and Frederick in a manner that complements existing perinatal programs. This area, identified at the CCH PSA, overlaps both hospitals' current service areas.

In FY 2008, 2,386 discharges were reported by Maryland hospitals among residents of the CCH PSA. In light of the relatively modest growth in Obstetrics discharges since 1997, we have forecasted that CCH would discharge 1,262 PSA residents, 58% of the total need in 2015, with exception of cases best served in either Frederick Memorial Hospital's or Shady Grove Adventist Hospital's existing Level III perinatal centers. The balance of total obstetrics cases at CCH in 2015 (430) would be among residents of areas not located in the PSA.

The following is offered in response to the Question found under d. above:

Because the CCH will be operating in close cooperation with the Level III Perinatal Programs at both Frederick Memorial Hospital and Shady Grove Adventist Hospital, we would respectfully suggest that any evaluation of the health status improvements called for in the CCH Community Benefit Plan for Obstetric and Perinatal Services be evaluated in conjunction with these two Programs. This Plan will expand upon the existing experience of Shady Grove Adventist Hospital and Washington Adventist Hospital as participants in the Montgomery County Maternity Partnership Program, providing prenatal health services and education for the low-income and uninsured population. (See CON Application, Attachment 1).

In the meantime, as contemplated, the Plan will provide measurable outcomes for evaluating health status improvements. Among the outcomes to be measured will be: 1) decreases in low birth weight newborns as a percentage of all newborns, 2) increases in the number of pre-natal visits, 3) decreases in infant mortality. Intermediate measurable outcomes contributing to improvements in health status will also include: 1) growth in attendance at service and educational programs, and 2) growth in the availability and utilization of infant car seats.

The following is offered in response to the Question found under e. above:

The structure, staffing and funding of the CCH Community Benefit Plan for Obstetric and Perinatal Services will be developed in conjunction with the existing Level III Perinatal Programs at Frederick Memorial Hospital and Shady Grove Adventist Hospital.

The planning for CCH has not progressed to date to a point where the clinical specialists at both Hospitals have been consulted concerning the structure, staffing and funding of the CCH Plan. The initial model was developed in reference to the existing Program at Shady Grove Adventist Hospital, but this will be examined again prior to the commencement of services at CCH.

We anticipate that as the CON review progresses, additional information and details regarding this initiative will be discussed collaboratively to assure that the necessary medical, nursing, consumer and administrative input is obtained from both Hospital communities, and shared with the Commission for public review.

The following is offered in response to the Question found under f. above:

As noted in our response above, while there is significant and documented community support for the approval, development and operation of the CCH, little community involvement has been solicited in formulating the CCH Community Benefit Plan for Obstetric and Perinatal Services to date. In our view, this involvement will take place as the specific elements of the Plan are discussed, analyzed and adopted by the clinical and administrative representatives of both Frederick Memorial Hospital and Shady Grove Adventist Hospital.

14. While the response to Completeness Question 32 provides current obstetric payor mix data by hospital for the obstetric discharges from the proposed service area of the new hospital, the data provided does not address the overall payor mix of the obstetrics services of these hospitals and the degree to which such payor mix will change as a result of the proposed service. Please address this component of Standard .04(13), Impact on the Health Care System (subsection b).

Applicant Response:

Had CCH been providing Obstetrics services for the FY 2008 period, we assume that the reduction of 1,216 OB discharges among residents of the PSA to other Maryland hospitals would have been proportionate to their market share by payer, with one exception.

Holy Cross had the largest proportion of Kaiser Permanente obstetrics patients among the Maryland hospitals due to its special relationship, and that proportion would not change as a result of the utilization of CCH by PSA residents for obstetrics services. We have kept the proportion of HMO OB discharges to Holy Cross (11.86%) constant to reflect this relationship.

Therefore, among the 2,386 PSA residents who were discharged from any Maryland hospital for OB, we would suggest that the impact on each hospital by payer would have been as shown below:

Payer	CCH	SGAH	FMH	HX	MGH	Other MD	Total
Medicare	1	1	0	0	0	0	2
Medicaid	148	39	1	74	4	10	276
Blue Cross	52	26	4	7	0	1	91
Commercial	223	117	20	36	18	3	417
Other Govt	2	0	1	0	0	0	3
Self Pay	24	6	3	4	0	1	38
Charity	2	0	0	2	0	0	4
HMO	375	206	23	272	13	7	896
Medicaid HMO	205	84	8	11	22	5	335
Medicare HMO	1	0	0	0	0	0	1
Blue Cross	151	72	17	15	8	1	264
Blue Cross	29	0	5	12	3	1	50
Other	5	4	0	0	0	0	9
Grand Total	1,216	555	82	434	68	29	2,386

Source: Maryland Discharge Abstract, for MDC 14.

The following chart shows the loss of OB discharges by payor at the existing Maryland hospitals had CCH been operating in FY 2008.

Payer	SGAH	FMH	HX	MGH	Other MD	Total
Medicare	-1	0	0	0	0	-1
Medicaid	-48	-4	-76	-6	-14	-148
Blue Cross	-34	-7	-8	-1	-3	-52
Commercial	-131	-26	-38	-21	-7	-223
Other Govt	0	-2	0	0	0	-2
Self Pay	-9	-6	-5	0	-4	-24
Charity	0	0	-2	0	0	-2
HMO	-308	-32	-11	-15	-9	-375
Medicaid HMO	-146	-12	-12	-27	-8	-205
Medicare HMO	0	0	0	0	-1	-1
Blue Cross	-99	-23	-15	-10	-4	-151
Blue Cross	0	-10	-13	-3	-3	-29
Other	-5	0	0	0	0	-5
Grand Total	-781	-122	-179	-83	-53	-1,216

Source: Maryland Discharge Abstract, for MDC 14.

The following chart shows the changes in payer mix of OB discharges by payor at the existing Maryland hospitals had CCH been operating in FY 2008:

	Frederick Memorial Hospital		Holy Cross Hospital of Silver Spring		Montgomery General Hospital		Shady Grove Adventist Hospital		Other MD	
Payer	Before	After	Before	After	Before	After	Before	After	Before	After
Medicare	0.1%	0.1%	0.1%	0.1%	0.3%	0.3%	0.1%	0.1%	0.4%	0.4%
Medicaid	9.4%	9.7%	17.8%	17.3%	5.1%	4.9%	8.0%	8.3%	10.3%	10.2%
Title V	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Blue Cross	3.9%	3.8%	3.2%	3.2%	1.5%	1.5%	4.5%	4.6%	9.8%	9.8%
Commercial	22.1%	22.1%	11.6%	11.4%	26.7%	26.9%	17.3%	17.4%	14.1%	14.1%
Other Govt	1.3%	1.2%	0.2%	0.2%	0.7%	0.8%	0.0%	0.0%	1.5%	1.5%
Workmens Comp	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Self Pay	5.8%	5.8%	1.6%	1.6%	1.0%	1.1%	1.2%	1.2%	2.4%	2.4%
Charity	0.0%	0.0%	0.3%	0.3%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Other	0.0%	0.0%	0.0%	0.0%	0.4%	0.5%	0.9%	0.9%	0.3%	0.3%
HMO	16.1%	15.6%	40.7%	41.3%	24.8%	25.4%	35.4%	34.7%	20.2%	20.2%
Medicaid - HMO	18.6%	19.0%	13.6%	13.7%	24.7%	23.9%	16.2%	15.8%	32.8%	32.8%
Medicare - HMO	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Blue Cross - Capital Area	15.5%	15.4%	7.1%	7.1%	12.2%	12.2%	16.3%	17.0%	3.4%	3.4%
Blue Cross - Other State	7.3%	7.2%	3.9%	3.8%	2.6%	2.5%	0.0%	0.0%	4.6%	4.6%

Source: Maryland Discharge Abstract, for MDC 14.

Payer	Frederick Memorial Hospital		Holy Cross Hospital of Silver Spring		Montgomery General Hospital		Shady Grove Adventist Hospital		Other MD	
	Before	After	Before	After	Before	After	Before	After	Before	After
Medicare	2	2	8	8	3	3	7	6	260	260
Medicaid	253	249	1,739	1,663	49	43	405	357	6,441	6,427
Title V	-	-	-	-	-	-	-	-	30	30
Blue Cross	105	98	314	306	14	13	230	196	6,159	6,156
Commercial	593	567	1,136	1,098	257	236	876	745	8,888	8,881
Other Govt	34	32	16	16	7	7	-	-	960	960
Workmens Comp	-	-	-	-	-	-	-	-	16	16
Self Pay	155	149	156	151	10	10	59	50	1,523	1,519
Charity	-	-	31	29	-	-	-	-	14	14
Other	1	1	-	-	4	4	44	39	175	175
HMO	432	400	3,976	3,965	238	223	1,797	1,489	12,710	12,701
Medicaid - HMO	499	487	1,329	1,317	237	210	824	678	20,582	20,574
Medicare - HMO	-	-	-	-	-	-	1	1	19	18
Blue Cross - Capital Area	417	394	695	680	117	107	828	729	2,137	2,133
Blue Cross - Other State	195	185	379	366	25	22	-	-	2,914	2,911
	2,686	2,564	9,779	9,599	961	878	5,071	4,290	62,828	62,775

Source: Maryland Discharge Abstract, for MDC 14.

15. Regarding the response to Completeness Question 34, please provide the following clarifications:

a. Submit the Montgomery County population data from Claritas that was used to compute the weighting for each zip code area in the Primary Service Area as described on pages 31 and 32;
b. Please reconcile the statement on page 34 that 75% o the forecasted Primary Service Area demand will be addressed by CCH with the use of 58% on page 57 of the application; and
c. Please describe the basis for the calculation of the need for 119 MSGA beds cited on page 34 and relate this bed need forecast to the forecasted need for 146 beds in Attachment 5 of the completeness response.

Applicant Response:

The following is offered in response to the Question found under a. above:

The Montgomery County population forecasts from Claritas was not used to compute the weighing for each zip code area in the Primary Service Area as described on page 31 and 32 of the Response to Completeness Question 34. The Claritas forecasts by zip code only were available through 2013, thus we developed our forecasts with reference to the Montgomery County population forecasts through 2020 obtained from the Maryland Department of Planning population dataset found on Attachment 6

The following is offered in response to the Question found under b. above:

The statement that 75% of the forecasted PSA demand will be addressed by CCH on page 34 of the Response to Completeness Question 34 is incorrect. The correct citation should be 59%.

The following is offered in response to the Question found under c. above:

The difference between the two MSGA bed need forecasts is the result of selecting different values for the ALOS and discharge rate variables for the CCH PSA. Both calculations are found on p. 55 of the CON application.

16. The response to Completeness Question 36 does not address why Table 3 includes projected depreciation on ongoing acquisitions in the first years of operation of a new facility including $594,000 in 2015 and why any such acquisitions should not be included in the project budget and project depreciation. Please address these issues.

Applicant Response:

Table 3 (per the original CON submission) includes projected depreciation on ongoing acquisitions in the first years of operation including $594,000 in 2015. This depreciation component is related to capital acquisitions of $1,500,000, $2,000,000 and $2,500,000 during the years 2013, 2014, and 2015, respectively. The capital acquisitions projected during years 2013 and 2014 are assumed to be funded by the HUD AMPO Fund (HUD requires a contingency type of fund just in case overruns are incurred in order to make the project operational; these contingency type funds are assumed to be spent for nonproject equipment which is usually how the funds are expended) in the amounts of $1,500,000 and $1,518,800, respectively. The remaining approximate $3,000,000 of equipment purchases not funded by the HUD AMPO Fund has been included to be conservative.

ATTACHMENTS

1. Inflation Allowance Calculation
2. Revised Project Budget
3. Calculation of Gross Construction Period Interest
4. Two Corrected Tables
5. Zip Code Areas of Local Access Areas
6. MDP Population Forecasts for Montgomery County

ATTACHMENT 1

ATTACHMENT 1

Clarksburg Community Hospital

June 18, 2009 CON Completeness Questions - Response to Question 2, Inflation Calculation

DELFATION OF HBE BUDGET - INCLUDED IN INFLATION ALLOWANCE

ATTACHMENT ____

HBE Construction Components:	Initial HBE Budget as of OCT 2010	Deflate HBE Budget* 3.75%	HBE Deflated to 4/1/2009
Building	$ 73,870,000	$ 2,670,000	$ 71,200,000
Site preparation	6,230,000	225,000	6,005,000
Architecht & engineering	8,900,000	322,000	8,578,000
	89,000,000	3,217,000	85,783,000
Contingency - 7.0%	6,230,000	225,000	6,005,000
Total HBE Budget including contingency	$ 95,230,000	$ 3,442,000	$ 91,788,000

**Deflate at 2.5% from OCT 2010 to APR 2009 - 18 months (3.75% total) - and include deflation component in the Sources and Uses Inflation Allowance*

INFLATION ALLOWANCE - SOURCES AND USES

	Initial Budget - Includes Inflation	Inflation Rates	Inflation Allowance
HBE - 89,000,000 PLUS 7% contingency budgeted in Oct 2010 $'s - inflated for 6 months at 2.5% to the start of construction in Apr 2011	$ 95,230,000		
deflated to APR 2010 - see details in above schedule	(3,442,000)		
	91,788,000	1.25%	1,147,000
All other costs - excluding inflation - inflated for 24 months at 2.5% from Apr 2009 to the start of construction in Apr 2011	47,355,000	5.00%	2,368,000
Total Current Capital Costs	139,143,000		3,515,000
HBE Deflation component - group with inflation on CON	3,442,000		3,442,000
Inflation	3,515,000		
Inflation Allowance - total	6,957,000		
Total Capital Costs - Including Inflation Allowanace	$ 146,100,000		$ 6,957,000

ATTACHMENT 2

ATTACHMENT 2

Clarksburg Community Hospital

June 18, 2009 CON Completeness Questions - Response to Question 3

PART II - PROJECT BUDGET - Revised

(INSTRUCTION: All estimates for 1.a.-e., 2.a.-h., and 3 are for current costs as of the date of application submission and should include the costs for all intended construction and renovations to be undertaken)		Revision	$ Change	Original Submission
A. Uses of Funds				
1. Capital Costs				
a. New Construction				
(1) Building	**Deflated at 2.5% per annum, 18 months, not compounded- reclassified $3,217,000 to inflation**	$ 80,294,000	$ (3,217,000)	$ 89,000,000
	Reclassify Architect/Engineering Fees to Line 1a(5)		$ (8,900,000)	
	Net regrouping to details below		$ 3,411,000	
(2) Fixed Equipment (Not Included in Construction)		-		-
(3) Land Purchase		-		-
(4) Site Preparation	**Note: Includes $270,000 landscaping**	6,500,000	-	6,500,000
(5) Architect/Engineering Fees	**Reclassify Architect/Engineering Fees from Line 1a(1)**	8,900,000	8,900,000	-
(6) Permits, (Building, Utilities, Insurance, Etc.)	**Note: Includes Connection Fees, APFO, Roads, Water Sewer of $1,792,000**	3,746,000		3,746,000
SUBTOTAL		$ 99,440,000	$ 194,000	$ 99,246,000
b. Renovations				
(1) Building & Fixed Equipment		$ -		$ -
(2) Fixed Equipment (Not Included in Construction)				
(3) Architect/Engineering Fees				
(4) Permits, (Building, Utilities, Etc.)				
SUBTOTAL		$ -	$ -	$ -
c. Other Capital Costs				
(1) Major Movable Equipment		20,165,000		20,165,000
(2) Minor Movable Equipment	**Description Changed**	1,900,000		1,900,000
(3) Contingencies	**Deflated Building Component - reclassified to inflation**	9,277,000	(225,000)	9,502,000
(4) Other (Specify)				
a. Signage/Security		1,424,000		1,424,000
b. IT/Telephone Fit-Out		6,187,000		6,187,000
c. Consulting Services		750,000		750,000
d. Connection Fees, APFO, Roads, Water Sewer	**Corrected summary total - component already included in Item 1a(6) above**	-	(1,792,000)	1,792,000
e. Other	**Reclassified $1,688,000 to Building per response to Q. 13**	-	(1,688,000)	1,688,000
TOTAL CURRENT CAPITAL COSTS (A - C)		$ 139,143,000	$ (3,511,000)	$ 142,654,000
d. Inflation Allowance	**Reclassified deflation from Building**	6,957,000	3,217,000	3,446,000
	Reclassified deflation from Building contingency		225,000	
	Inflation Rounding		69,000	
e. Capitalized Construction Interest (gross)	**Reclassified interest income on bond funds during construction period to source of funds***	18,964,000	3,024,460	15,939,540
TOTAL PROPOSED CAPITAL COSTS (a-e)		165,064,000	3,024,460	162,039,540

2.	Financing Costs and Other Cash Requirements				
	a. Loan Placement Fees	$ -		$ -	
	b. Bond Discount	-		-	
	c. Bond Financing Expenses	8,750,000		8,750,000	
	d. Legal Fees (Other)	-		-	
	e. Printing	-		-	
	f. Consultant Fees:	-		-	
	CON Application Assistance	150,000		150,000	
	Other (Specify)	-		-	
	g. Liquidation of Existing Debt	-		-	
	h. Debt Service Reserve Fund	8,195,000		8,195,000	
	I. Principal Amortization	-		-	
	Reserve Fund	-		-	
	j. Other (Specify)	-		-	
	HUD AMPO Fund	3,018,800		3,018,800	
	TOTAL (a - j)	$ 20,113,800	$ -	$ 20,113,800	
3.	Working Capital Startup Costs/Transition Costs	$ 20,000,000	$ -	$ 20,000,000	
	TOTAL USES OF FUNDS (1 - 3)	**$ 205,177,800**	**$ 3,024,460**	**$ 202,153,340**	
B.	**Sources of Funds for Project:**				
1.	Cash	$ 8,018,340		$ 8,018,340	
	Pledges: Gross $_____				
	less allowance for uncollectibles $0,				
2.	= $_____, NET	-		-	
3.	Gifts, bequests	15,000,000		15,000,000	
	Interest income (gross) On Trustee Funds				
4.	(Added to Capitalized Interest Fund)	3,024,460	3,024,460	-	
5.	Authorized Bonds	159,135,000		159,135,000	
6.	Working Capital Loan	20,000,000		20,000,000	
7.	Grants or Appropriation				
	(a) Federal				
	(b) State				
	(c) Local				
8.	Other - Proceeds from Capital Lease Financings				
	rounding	-			
	TOTAL SOURCES OF FUNDS (1 - 9)	**$ 205,177,800**	**$ 3,024,460**	**$ 202,153,340**	

		-	-	-
Lease Costs:				
a. Land*	$	500,000	x 50 years =	$ 25,000,000
b. Building		N/A	N/A	N/A
c. Major Movable Equipment		N/A	N/A	N/A
d. Minor Movable Equipment		N/A	N/A	N/A
e. Other (specify)		N/A	N/A	N/A

*The land will be leased from Adventist HealthCare.
The lease will begin upon start of construction of the facility.
Adventist HealthCare owns the land, which has a total carrying cost of approximately $10,000,000: approximately $5,000,000 has been assigned to the hospital lease.

ATTACHMENT 3

ATTACHMENT 3

Clarksburg Community Hospital

June 18, 2009 CON Completeness Questions - Response to Question 5, Construction Period Interest and Interest Income

ATTACHMENT ____

Interest Expense - Gross, during Construction Period:

(Interest payments funded for the construction period, plus 1 month of operations.

	Bond Issue	Period	Interest Rate Tax-Exempt Bonds	Interest Expense	Months
$	159,135,000	4/1/2011 - 7/1/2011	6.50%	$ 2,586,000	3
	159,135,000	7/1/2011 - 1/1/2012	6.50%	5,172,000	6
	159,135,000	1/1/2012 - 7/1/2012	6.50%	5,172,000	6
	159,135,000	7/1/2012 - 1/1/2013	6.50%	5,172,000	6
				$ 18,102,000	
			Interest expense funded for FY 2013		
			1 month of operations	862,000	1
			Gross interest expense	**18,964,000**	22

Interest income earned during construction period on tax-exempt bond funds:

	Approximate Interest rate	Interest income
Debt service reserve fund	3%	$ 409,800
Capitalized interest fund	2%	415,400
Construction fund assumed funds drawn down evenly during the construction period	2%	2,199,260
Gross interest income		**$ 3,024,460**

ATTACHMENT 4

RESUBMITTED TABLE WITH ARITHMATIC CORRECTIONS and UPDATED FOR CY 2008 DISCHARGES

Clarksburg Community Hospital PSA 2017 MSGA BED NEED METHODOLOGY

Clarksburg PSA Discharges, Inpatient Days, ALOS for Age Groups 15-64 and 65+, Calendar Years 1997-2007

	Adult Population		CY Discharges		TOTAL	CY Inpatient Days		TOTAL	CY ALOS		USE RATE (discharges/1000 pop)		Annual Change			
YEAR	15-64	65+	15-64	65+	DISCHARGES	15-64	65+	DAYS	15-64	65+	15-64	65+	Use Rate 15-64	Use Rate 65+	ALOS 15-64	ALOS 65+
1997	85,933	3,809	2,750	1,267	4,017	10,720	7,801	18,521	3.90	6.16	32.00	332.59				
1998	87,176	4,163	2,826	1,331	4,157	10,798	7,462	18,260	3.82	5.61	32.42	319.71	1.3%	-3.9%	-2.0%	-8.9%
1999	88,437	4,550	3,058	1,459	4,517	10,995	8,654	19,649	3.60	5.93	34.58	320.68	6.7%	0.3%	-5.9%	5.6%
2000	89,717	4,972	3,202	1,584	4,786	12,182	8,936	21,118	3.80	5.71	35.69	314.55	3.2%	-1.9%	5.8%	-3.7%
2001	91,015	5,434	3,289	1,806	5,095	12,138	9,922	22,060	3.69	5.49	36.14	332.36	1.3%	5.7%	-3.0%	-3.8%
2002	92,332	5,938	3,815	1,835	5,650	14,638	10,001	24,639	3.84	5.45	41.32	309.00	14.3%	-7.0%	4.0%	-0.8%
2003	93,668	6,490	3,827	1,993	5,820	14,572	10,699	25,271	3.81	5.37	40.86	307.09	-1.1%	-0.6%	-0.8%	-1.5%
2004	95,023	7,093	3,722	2,209	5,931	13,165	12,702	25,867	3.54	5.75	39.17	311.45	-4.1%	1.4%	-7.1%	7.1%
2005	96,398	7,751	3,990	2,171	6,161	14,610	10,826	25,436	3.66	4.99	41.39	280.09	5.7%	-10.1%	3.5%	-13.3%
2006	97,793	8,471	4,008	2,286	6,294	13,915	10,617	24,532	3.47	4.64	40.98	269.87	-1.0%	-3.6%	-5.2%	-6.9%
2007	99,208	9,257	4,360	2,455	6,815	16,488	11,740	28,228	3.78	4.78	43.95	265.19	7.2%	-1.7%	8.9%	3.0%
2008	100,643	10,117	4,524	2,743	7,267	17,556	13,813	31,369	3.88	5.04	44.95	271.13	2.3%	2.2%	2.6%	5.3%
2009	102,078	10,977	4,680	2,905	7,585	18,163	14,481	32,643	3.88	4.99	45.85	264.62	2.0%	-2.4%	0.0%	-1.0%
2010	103,514	11,909	4,841	3,076	7,917	18,786	15,181	33,967	3.88	4.94	46.77	258.27	2.0%	-2.4%	0.0%	-1.0%
2011	104,990	12,921	5,008	3,257	8,265	19,435	15,914	35,350	3.88	4.89	47.70	252.07	2.0%	-2.4%	0.0%	-1.0%
2012	106,487	14,019	5,181	3,449	8,630	20,107	16,684	36,790	3.88	4.84	48.68	246.02	2.0%	-2.4%	0.0%	-1.0%
2013	107,820	14,415	5,351	3,461	8,812	20,765	16,576	37,341	3.88	4.79	49.63	240.12	2.0%	-2.4%	0.0%	-1.0%
2014	109,358	15,640	5,536	3,665	9,201	21,483	17,377	38,860	3.88	4.74	50.62	234.35	2.0%	-2.4%	0.0%	-1.0%
2015	110,917	16,969	5,727	3,881	9,608	22,225	18,217	40,442	3.88	4.69	51.63	228.73	2.0%	-2.4%	0.0%	-1.0%
2016	112,499	18,410	5,925	4,110	10,035	22,993	19,098	42,090	3.88	4.65	52.67	223.24	2.0%	-2.4%	0.0%	-1.0%
2017	114,104	19,975	6,130	4,352	10,482	23,787	20,021	43,808	3.88	4.60	53.72	217.88	2.0%	-2.4%	0.0%	-1.0%
											Average Annual Change (5 year)		2.0%	-2.4%	0.0%	-1.0%
											Average Annual Change (10 year)		3.4%	-1.5%	0.3%	-0.9%

Bed Need for CCH PSA - LOW RANGE	15-64	65+	Total	ADC	Beds
2007 Days	16,488	11,740	28,228	77	103
2017 Population	114,104	19,975			
Use Rate	53.72	217.88			
ALOS	3.88	4.60			
Days	23,787	20,021	43,808	120	150
Additional Bed Need					47

RESUBMITTED TABLE WITH ARITHMATIC CORRECTIONS and UPDATED FOR CY 2008 DISCHARGES

Clarksburg Community Hospital PSA 2017 MSGA BED NEED METHODOLOGY

Clarksburg PSA Discharges, Inpatient Days, ALOS for Age Groups 15-64 and 65+, Calendar Years 1997-2007

	Adult Population		CY Discharges		TOTAL	CY Inpatient Days		TOTAL	CY ALOS		USE RATE (discharges/1000 pop)		Annual Change			
YEAR	15-64	65+	15-64	65+	DISCHARGES	15-64	65+	DAYS	15-64	65+	15-64	65+	Use Rate 15-64	Use Rate 65+	ALOS 15-64	ALOS 65+
1997	85,933	3,809	2,750	1,267	4,017	10,720	7,801	18,521	3.90	6.16	32.00	332.59				
1998	87,176	4,163	2,826	1,331	4,157	10,798	7,462	18,260	3.82	5.61	32.42	319.71	1.3%	-3.9%	-2.0%	-8.9%
1999	88,437	4,550	3,058	1,459	4,517	10,995	8,654	19,649	3.60	5.93	34.58	320.68	6.7%	0.3%	-5.9%	5.8%
2000	89,717	4,972	3,202	1,564	4,766	12,182	8,936	21,118	3.80	5.71	35.69	314.55	3.2%	-1.9%	5.8%	-3.7%
2001	91,015	5,434	3,289	1,806	5,095	12,138	9,922	22,060	3.69	5.49	36.14	332.36	1.3%	5.7%	-3.0%	-3.8%
2002	92,332	5,938	3,815	1,835	5,650	14,638	10,001	24,639	3.84	5.45	41.32	309.00	14.3%	-7.0%	4.0%	-0.8%
2003	93,668	6,490	3,827	1,993	5,820	14,572	10,699	25,271	3.81	5.37	40.86	307.09	-1.1%	-0.6%	-0.8%	-1.5%
2004	95,023	7,093	3,722	2,209	5,931	13,165	12,702	25,867	3.54	5.75	39.17	311.45	-4.1%	1.4%	-7.1%	7.1%
2005	96,398	7,751	3,990	2,171	6,161	14,610	10,826	25,436	3.66	4.99	41.39	280.09	5.7%	-10.1%	3.5%	-13.3%
2006	97,793	8,471	4,008	2,286	6,294	13,915	10,617	24,532	3.47	4.64	40.98	269.87	-1.0%	-3.6%	-5.2%	-6.9%
2007	99,208	9,267	4,360	2,455	6,815	16,488	11,740	28,228	3.78	4.78	43.95	265.19	7.2%	-1.7%	8.8%	3.0%
2008	100,643	10,117	4,524	2,743	7,267	17,556	13,813	31,369	3.88	5.04	44.95	271.13	2.3%	2.2%	2.6%	5.3%
2009	102,078	10,977	4,745	2,931	7,676	18,467	14,718	33,185	3.89	5.02	46.48	267.06	3.4%	-1.5%	0.3%	-0.3%
2010	103,514	11,909	4,975	3,133	8,108	19,422	15,681	35,103	3.90	5.01	48.06	263.05	3.4%	-1.5%	0.3%	-0.3%
2011	104,990	12,921	5,217	3,348	8,565	20,429	16,708	37,138	3.92	4.99	49.69	259.11	3.4%	-1.5%	0.3%	-0.3%
2012	106,487	14,019	5,472	3,578	9,050	21,490	17,802	39,292	3.93	4.98	51.38	255.22	3.4%	-1.5%	0.3%	-0.3%
2013	107,820	14,415	5,729	3,624	9,352	22,566	17,977	40,542	3.94	4.96	53.13	251.39	3.4%	-1.5%	0.3%	-0.3%
2014	109,358	15,640	6,008	3,873	9,881	23,737	19,154	42,891	3.95	4.95	54.94	247.62	3.4%	-1.5%	0.3%	-0.3%
2015	110,917	16,969	6,301	4,139	10,439	24,968	20,408	45,377	3.96	4.93	56.80	243.91	3.4%	-1.5%	0.3%	-0.3%
2016	112,499	18,410	6,608	4,423	11,031	26,264	21,745	48,009	3.97	4.92	58.74	240.25	3.4%	-1.5%	0.3%	-0.3%
2017	114,104	19,975	6,930	4,727	11,657	27,627	23,169	50,796	3.99	4.90	60.73	236.65	3.4%	-1.5%	0.3%	-0.3%
									Average Annual Change (5 year)				2.0%	-2.4%	0.0%	-1.0%
									Average Annual Change (10 year)				3.4%	-1.5%	0.3%	-0.9%

Bed Need for CCH PSA - HIGH RANGE	15-64	65+	Total	ADC	Beds
2007 Days	16,488	11,740	28,228	77	103
2017 Population	114,104	19,975			
Use Rate	60.73	236.65			
ALOS	3.99	4.90			
Days	27,627	23,169	50,796	139	174
Additional Bed Need					71

ATTACHMENT 5

Rich Coughlan

From: Saved by Windows Internet Explorer 7
Sent: Monday, March 23, 2009 11:23 AM
Subject: 10.09.66.06

10.09.66.06

.06 Geographical Access.

A. An MCO shall develop and maintain a provider network that ensures that enrollees have reasonable travel times to the sites at which they receive the following services:

(1) Primary care;

(2) Pharmacy;

(3) OB/GYN;

(4) Dental for enrollees younger than 21 years old; and

(5) Diagnostic laboratory and X-ray.

B. Except as provided in §D of this regulation, to meet the geographical access standard established by this regulation, an MCO shall provide the services listed in §A(1) and (3)—(5) of this regulation:

(1) In urban areas, within 30 minutes travel time or within a 10-mile radius of each enrollee's residence; and

(2) In rural areas, within 30 minutes travel time or within 30 miles of each enrollee's residence.

C. Except as provided in §D of this regulation, to meet the geographical access standard established by this regulation, an MCO shall provide pharmacy services in:

(1) Urban areas, within 10 minutes travel time or within a 5-mile radius of each enrollee's residence; and

(2) Rural areas, within 30 minutes travel time or within 30 miles of each enrollee's residence.

D. If an MCO can otherwise demonstrate to the Department's satisfaction the adequacy of its provider network notwithstanding its inability to meet the requirements of §§B and C of this regulation, the Department may, in its discretion, approve the network if special circumstances exist which, considered along with the overall strength of the MCO's network, establish that the Department's approval of the network will enhance recipients' overall access to quality health care services in the area to be served.

E. Geographical Access: Local Access Areas.

Local Access Area	*Zip Codes*
Allegany	21501, 21502, 21503, 21504, 21505, 21521, 21523, 21524, 21528, 21529, 21530, 21532, 21539, 21540, 21542, 21543, 21545, 21546, 21555, 21556, 21557, 21560, 21562, 21766
Anne Arundel North	20701, 20724, 20755, 21056, 21060, 21061, 21076, 21077, 21090, 21108, 21113, 21122, 21123, 21144, 21240

Anne Arundel South	20711, 20733, 20751, 20764, 20765, 20776, 20778, 20779, 21012, 21032, 21035, 21037, 21054, 21106, 21114, 21140, 21146, 21401, 21402, 21403, 21404, 21405, 21409
Baltimore City SE/Dundalk	21052, 21219, 21222, 21224, 21281
Baltimore City East	21202, 21203, 21205, 21213, 21231, 21287
Baltimore City North Central	21210, 21211, 21218
Baltimore City Northeast	21206, 21212, 21214, 21239
Baltimore City Northwest	21208, 21209, 21215, 21270
Baltimore City South	21225, 21226, 21230
Baltimore City West	21201, 21216, 21217, 21223
Baltimore County East	21021, 21022, 21027, 21051, 21087, 21128, 21156, 21162, 21220, 21221, 21236, 21237
Baltimore County North	21013, 21023, 21030, 21031, 21053, 21057, 21082, 21092, 21093, 21094, 21105, 21111, 21120, 21131, 21139, 21152, 21153, 21155, 21161, 21204, 21234, 21284, 21285, 21286
Baltimore County Northwest	21055, 21071, 21117, 21133, 21136, 21163, 21207, 21244, 21282
Baltimore County Southwest	21227, 21228, 21229
Calvert	20610, 20615, 20629, 20639, 20657, 20676, 20678, 20685, 20688, 20689, 20714, 20732, 20736, 20754, 20758
Caroline	21609, 21629, 21632, 21636, 21639, 21640, 21641, 21649, 21655, 21660, 21670
Carroll	21020, 21048, 21074, 21088, 21102, 21104, 21157, 21158, 21757, 21771, 21776, 21784, 21787, 21791
Cecil	21901, 21902, 21903, 21904, 21911, 21912, 21913, 21914, 21915, 21916, 21917, 21918, 21919, 21920, 21921, 21922, 21930
Charles	20601, 20602, 20603, 20604, 20611, 20612, 20616, 20617, 20622, 20625, 20632, 20637, 20640, 20643, 20645, 20646, 20658, 20661, 20662, 20664, 20675, 20677, 20682, 20693, 20695
Dorchester	21613, 21622, 21626, 21627, 21631, 21634, 21643, 21648, 21659, 21664, 21669, 21672, 21675, 21677, 21835, 21869
Frederick	21701, 21702, 21703, 21704, 21705, 21710, 21714, 21716, 21717, 21718, 21727, 21754, 21755, 21758, 21759, 21762, 21769, 21770, 21773, 21774, 21775, 21777, 21778, 21780, 21788, 21790, 21792, 21793, 21798
Garrett	21520, 21522, 21531, 21536, 21538, 21541, 21550, 21561
Harford East	21001, 21005, 21017, 21018, 21024, 21028, 21034, 21078, 21130
Harford West	21009, 21010, 21014, 21015, 21040, 21047, 21050, 21084, 21085, 21101, 21132, 21154, 21160
Howard County	20723, 20759, 20763, 20777, 20794, 21029, 21036, 21041, 21042, 21043, 21044, 21045, 21046, 21150, 21723, 21737, 21738, 21765, 21794, 21797

Kent	21610, 21620, 21635, 21637, 21645, 21646, 21650, 21661, 21667, 21678
Montgomery Mid-County	20812, 20813, 20814, 20815, 20816, 20817, 20818, 20824, 20825, 20827, 20830, 20832, 20833, 20848, 20849, 20850, 20851, 20852, 20853, 20854, 20855, 20857, 20859, 20889, 20891, 20892, 20895, 20896
Montgomery North	20837, 20838, 20839, 20841, 20842, 20847, 20871, 20872, 20874, 20875, 20876, 20877, 20878, 20879, 20880, 20882, 20883, 20884, 20885, 20886, 20898, 20997
Montgomery - Silver Spring	20860, 20861, 20862, 20866, 20868, 20901, 20902, 20903, 20904, 20905, 20906, 20907, 20908, 20910, 20911, 20912, 20913, 20914, 20915, 20916, 20918, 20990
Prince George's Northeast	20704, 20705, 20707, 20708, 20709, 20715, 20716, 20717, 20718, 20719, 20720, 20721, 20725, 20726, 20769
Prince George's Northwest	20703, 20706, 20710, 20712, 20722, 20731, 20737, 20738, 20740, 20741, 20742, 20743, 20768, 20770, 20771, 20780, 20781, 20782, 20783, 20784, 20785, 20787, 20788, 20789, 20791, 20792, 20797, 20799
Prince George's Southeast	20608, 20613, 20623, 20735, 20762, 20772, 20773, 20774, 20775
Prince George's Southwest	20607, 20744, 20745, 20746, 20747, 20748, 20749, 20750, 20752, 20753, 20757, 20790
Queen Anne's	21607, 21617, 21619, 21623, 21628, 21638, 21644, 21651, 21656, 21657, 21658, 21666, 21668
Somerset	21816, 21817, 21820, 21821, 21824, 21836, 21838, 21853, 21857, 21866, 21867, 21686, 21870, 21871, 21890
St. Mary's	20606, 20609, 20618, 20619, 20620, 20621, 20624, 20626, 20627, 20628, 20630, 20634, 20635, 20636, 20650, 20653, 20656, 20659, 20660, 20667, 20670, 20674, 20680, 20684, 20686, 20687, 20690, 20692
Talbot	21601, 21612, 21624, 21625, 21647, 21652, 21653, 21654, 21662, 21663, 21665, 21671, 21673, 21676, 21679
Washington	21711, 21713, 21715, 21719, 21720, 21721, 21722, 21733, 21734, 21740, 21741, 21742, 21746, 21750, 21756, 21767, 21779, 21781, 21782, 21783, 21795
Wicomico	21801, 20802, 21803, 21804, 21810, 21814, 21822, 21826, 21830, 21837, 21840, 21849, 21850, 21852, 21856, 21861, 21865, 21874, 21875
Worcester	21811, 21813, 21829, 21841, 21842, 21843, 21851, 21862, 21863, 21864, 21872

ATTACHMENT 6

2009 Total Population Projections by Age, Sex and Race (2/5/09)
Prepared by Maryland Department of Planning

New input data : Cntr1208_R9.dat (new control from 12-17-08)
Abrf0209_to2030.dat (new birth facter from 2-5-09 modify kent & frederick)

			0-4	5-9	10-14	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75-79	80-84	85+	Total
Montgomery Co.	2005	Total	65,324	61,808	65,133	65,501	53,324	50,478	60,467	70,352	79,521	77,779	71,176	57,447	41,514	29,815	23,145	21,383	17,216	17,723	929,106
		Total Male	33,448	31,496	33,369	33,197	27,670	24,680	29,248	33,438	37,767	36,984	33,388	27,010	19,580	13,652	10,439	8,650	6,443	6,033	446,492
		Total Female	31,876	30,312	31,764	32,304	25,654	25,798	31,219	36,914	41,754	40,795	37,788	30,437	21,934	16,163	12,706	12,733	10,773	11,690	482,614
		Total White Alone	38,195	39,987	42,653	43,906	34,204	32,021	37,373	45,275	53,381	54,611	52,092	42,070	30,630	21,979	17,613	17,625	14,733	15,417	633,765
		White Male	19,545	20,418	21,819	22,248	18,058	15,911	18,615	22,172	25,781	26,467	24,964	20,115	14,618	10,119	7,956	7,108	5,484	5,266	306,664
		White Female	18,650	19,569	20,834	21,658	16,146	16,110	18,758	23,103	27,600	28,144	27,128	21,955	16,012	11,860	9,657	10,517	9,249	10,151	327,101
		Total All Other	27,129	21,821	22,480	21,595	19,120	18,457	23,094	25,077	26,140	23,168	19,084	15,377	10,884	7,836	5,532	3,758	2,483	2,306	295,341
		Non-white Male	13,903	11,078	11,550	10,949	9,612	8,769	10,633	11,266	11,986	10,517	8,424	6,895	4,962	3,533	2,483	1,542	959	767	139,828
		Non-white Female	13,226	10,743	10,930	10,646	9,508	9,688	12,461	13,811	14,154	12,651	10,660	8,482	5,922	4,303	3,049	2,216	1,524	1,539	155,513
	2010	Total	67,039	64,835	61,902	63,411	64,046	60,832	52,010	60,015	68,831	78,344	75,609	68,314	54,380	38,770	26,965	20,638	17,650	22,405	965,996
		Total Male	34,402	33,176	31,550	32,595	31,958	31,527	25,525	28,871	32,595	37,137	35,893	31,778	25,327	17,921	12,193	8,749	6,674	7,957	465,828
		Total Female	32,637	31,659	30,352	30,816	32,088	29,305	26,485	31,144	36,236	41,207	39,716	36,536	29,053	20,849	14,772	11,889	10,976	14,448	500,168
		Total White Alone	39,319	37,206	39,550	40,390	41,946	41,145	33,092	36,603	43,618	52,152	52,565	49,517	39,355	28,459	19,729	15,797	14,577	19,083	644,103
		White Male	20,160	18,951	20,158	20,720	20,696	21,618	16,469	18,071	21,219	25,114	25,447	23,493	18,630	13,286	8,940	6,627	5,409	6,763	311,771
		White Female	19,159	18,255	19,392	19,670	21,250	19,527	16,623	18,532	22,399	27,038	27,118	26,024	20,725	15,173	10,789	9,170	9,168	12,320	332,332
		Total All Other	27,720	27,629	22,352	23,021	22,100	19,687	18,918	23,412	25,213	26,192	23,044	18,797	15,025	10,311	7,236	4,841	3,073	3,322	321,893
		Non-white Male	14,242	14,225	11,392	11,875	11,262	9,909	9,056	10,800	11,376	12,023	10,446	8,285	6,697	4,635	3,253	2,122	1,265	1,194	154,057
		Non-white Female	13,478	13,404	10,960	11,146	10,838	9,778	9,862	12,612	13,837	14,169	12,598	10,512	8,328	5,676	3,983	2,719	1,808	2,128	167,836
	2015	Total	68,397	68,457	67,412	62,166	64,181	76,783	64,598	52,819	60,132	68,949	77,462	73,513	65,645	51,426	35,497	24,337	17,288	25,939	1,025,001
		Total Male	35,020	35,179	34,548	31,710	32,577	38,153	33,623	25,812	28,896	32,596	36,602	34,644	30,244	23,566	16,254	10,354	6,898	9,439	496,115
		Total Female	33,377	33,278	32,864	30,456	31,604	38,630	30,975	27,007	31,236	36,353	40,860	38,869	35,401	27,860	19,243	13,983	10,390	16,500	528,886
		Total White Alone	41,721	38,599	36,929	38,123	39,077	51,261	42,668	32,583	35,620	42,811	50,633	50,578	47,037	36,929	25,830	17,895	13,181	21,401	662,876
		White Male	21,398	19,701	18,777	19,413	19,659	25,141	22,457	16,097	17,475	20,754	24,292	24,270	22,110	17,201	11,915	7,538	5,098	7,714	321,010
		White Female	20,323	18,898	18,152	18,710	19,418	26,120	20,211	16,486	18,145	22,057	26,341	26,308	24,927	19,728	13,915	10,357	8,083	13,687	341,866
		Total All Other	26,676	29,858	30,483	24,043	25,104	25,522	21,930	20,236	24,512	26,138	26,829	22,935	18,608	14,497	9,667	6,442	4,107	4,538	362,125
		Non-white Male	13,622	15,478	15,771	12,297	12,918	13,012	11,166	9,715	11,421	11,842	12,310	10,374	8,134	6,365	4,339	2,816	1,800	1,725	175,105
		Non-white Female	13,054	14,380	14,712	11,746	12,186	12,510	10,764	10,521	13,091	14,296	14,519	12,561	10,474	8,132	5,328	3,626	2,307	2,813	187,020
	2020	Total	73,487	68,777	70,474	66,891	61,928	74,780	80,778	64,798	52,200	59,900	67,674	74,613	69,736	61,733	46,969	32,001	20,346	27,914	1,074,999
		Total Male	37,654	35,237	36,280	34,462	31,027	37,868	40,353	33,532	25,491	28,769	31,954	35,024	32,615	27,911	21,352	13,909	8,239	10,482	522,159
		Total Female	35,833	33,540	34,194	32,429	30,901	36,912	40,425	31,266	26,709	31,131	35,720	39,589	37,121	33,822	25,617	18,092	12,107	17,432	552,840
		Total White Alone	44,104	40,418	38,087	34,533	36,103	46,518	52,878	41,621	31,209	34,683	41,021	47,913	47,034	43,799	33,386	23,381	14,898	21,813	673,399
		White Male	22,656	20,633	19,404	17,660	17,827	23,292	25,972	21,698	15,326	16,973	19,863	22,792	22,415	20,176	15,398	10,143	5,857	8,016	326,101
		White Female	21,448	19,785	18,683	16,873	18,276	23,226	26,906	19,923	15,883	17,710	21,158	25,121	24,619	23,623	17,988	13,238	9,041	13,797	347,298
		Total All Other	29,383	28,359	32,387	32,358	25,825	28,262	27,900	23,177	20,991	25,217	26,653	26,700	22,702	17,934	13,583	8,620	5,448	6,101	401,600
		Non-white Male	14,998	14,604	16,876	16,802	13,200	14,576	14,381	11,834	10,165	11,796	12,091	12,232	10,200	7,735	5,954	3,766	2,382	2,466	196,058
		Non-white Female	14,385	13,755	15,511	15,556	12,625	13,686	13,519	11,343	10,826	13,421	14,562	14,468	12,502	10,199	7,629	4,854	3,066	3,635	205,542

AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in the foregoing comments and attachments are true and correct to the best of my knowledge, information, and belief.

Name

22 July 09
Date

AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in the foregoing comments and attachments are true and correct to the best of my knowledge, information, and belief.

Christopher C. Hall
Sr. Director Strategic Planning

July 23, 2009

AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in the foregoing comments and attachments are true and correct to the best of my knowledge, information, and belief.

Michael Rost — 22 July 09

Name — Date

Director

Adventist Healthcare

AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in the foregoing comments and attachments are true and correct to the best of my knowledge, information, and belief.

David S Cohen

July 21, 2009

Name

Date

AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in the foregoing comments and attachments are true and correct to the best of my knowledge, information, and belief.

R T Cayman
Name

7/22/09
Date